King Edward VII Memorial Hospital

Inspection Report

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Care system: Tax funded
https://falklands.gov.fk/health/

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Assessment Team

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Summary of findings

We have undertaken our inspection using methodology based largely on the Care Quality Commission in the United Kingdom. We have considered whether the services we have reviewed are safe, effective, responsive, caring and well-led. Across all areas inspected we have found the services to be good and, in some cases, outstanding. This is not to say that everything is perfect, and in the inspection report we openly address areas where we think services could be improved.

The inspection was made easy by virtue of the openness and professionalism of all the staff we encountered and by their willingness to engage constructively. We hope the inspection report is seen as a fair, unbiased, comprehensive and constructive review of the services we have reviewed within the agreed terms of reference. We also hope the report provides structure and impetus for continuous improvement.

Contents

1. Commonly used abbreviations

CMO	Chief Medical Officer
CPD	Continued Professional Development
CQC	Care Quality Commission
GP	General Practice
FIG	Falkland Islands Government
ILS	Immediate Life Support
KEMH	King Edward VII Memorial Hospital
M&M	Morbidity and Mortality
MDT	Multidisciplinary team
HMSC	Health and Medical Services Committee
MLA	Member of the Legislative Assembly
MOD	Ministry of Defense
MTO	Medical Treatment Overseas
NHS	National Health Service
SMT	Senior Management Team
UKOT	UK Overseas Territories

2. About our report

This report describes our judgement of the quality of care provided by this hospital. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from hospital staff, people who use the service, the public and other organisations.

We found evidence of good leadership from our inspection of hospital management, considering what we found about leadership in individual services in addition to the overall leadership of the hospital. Our summary of findings for other key questions was derived using our combined professional judgement.

3. Introduction

3.1. Background

The King Edward VII Memorial Hospital (KEMH) is the only hospital in the Falkland Islands. Although it is an Overseas British Territory, the Falkland Islands are internally self-governing with their own legal system. There is a limited amount of legislation relating to the regulation of medical services in the Falkland Islands and the health service is not part of the NHS, but as a British territory, the medical service is principally informed by UK guidance in relation to the standards of care it provides. UK guidance can, however, only ever be followed or implemented as far as is reasonably practicable within the resource constraints of a remote island archipelago with fewer than 4,000 residents.

The KEMH is a GP-led hospital, which provides a wide range of primary care services as well as secondary care services to the local population in an integrated, 'under one roof', model of care. The inherent nature of running a healthcare facility at such a scale of operation in such a remote environment means that the level of clinical risk held is often very high, as clinicians are often expected to work across a broader scope of practice than would be typical in a less remote setting, sometimes to the limits of their skill sets, knowledge and experience. Medical treatment overseas (MTO) is therefore a critical aspect of the KEMH's operational model where local resources, facilities, capability or capacity do not allow for treatment to occur in-house. In some circumstances, however, emergency medical evacuation cannot always occur as swiftly as would be optimal owing to logistical issues such as the airport being closed when rotor winds are forecast.

The Falkland Islands have a level 4 reciprocal agreement with the UK, and accordingly, most off-islands referrals are to the UK. Emergency medevacs and some other MTOs are sometimes referred to South America. The most time critical medevacs utilise an A400/ Voyager airframe, which is an RAF asset based at Mount Pleasant Airport. In these circumstances the KEMH provide the medical crew for the flight. Most medevac transfers to South America are, however, by private air ambulance.

The KEMH provides a number of services, including secondary care provision to the British Forces South Atlantic Islands (BFSAI) base at Mount Pleasant, approximately 35 miles distant from the KEMH. The exact nature and stipulations for the reciprocal services provided between the Ministry of Defence (MoD) and KEMH are outlined in the FIG-MOD Memorandum of Understanding for Medical Services. To provide the required level of assurance as part of the MoD's internal quality assurance

processes the KEMH has previously received periodic assurance visits from the MoD, which focussed on the areas of healthcare provision of interest to the MoD.

Notwithstanding the usefulness of above programme of MoD assurance visits, it was determined by KEMH senior management and Members of the Legislative Assembly (MLAs) that an independent review of the KEMH would be useful tool to provide an objective overview of the current status of healthcare provision at the KEMH.

3.2. Aim of the external inspection

The aim of this inspection was to provide an overview of the healthcare provision status at the KEMH by means of a six-day on-site inspection by suitably qualified individuals, supported by a written report in line with the terms of reference. The inspection aimed to identify areas of good practice for which support should be offered to maintain quality and areas where improvement can be made via a series of recommendations and appropriate support given to make feasible improvements within the context of the Falkland Islands.

3.3. Background to the assessment process

In early 2024, the KEMH director of health and social services undertook an initial review of the approaches to healthcare inspection in other UK overseas territories and crown dependencies. This included discussions with the Care Quality Commission (CQC) (English regulator), Healthcare Improvement Scotland, the Jersey Care Commission and UK Healthcare Ambassador to the UK Overseas Territories, Professor Ian Cumming. From these discussions it became apparent that inviting these organisations to apply the inspection framework of their country would be unfeasible because all organisations had clear capacity constraints that would limit such a venture being feasible in the short or medium term. In addition, adaptation of their frameworks would be challenging, especially since the organisations have limited experience of delivering such work outside their own jurisdiction. Furthermore, it was ascertained that whilst the uptake of such inspections across the UK Overseas Territories (UKOTs) has to date been very limited, an unmet need exists across the UKOTs for such an activity, and as such the UKOT branch of the UK Health Security Agency (UKHSA) would be interested in working with the Falkland Islands to trial a form of inspection that is appropriately tailored to the operational environment of each UKOT where such an inspection is requested. It is anticipated that the learning and outcomes from this approach may then be beneficial for other UKOTs.

3.4. How we carried out the inspection

We carried out the inspection on 11, 12, 13, 14, 15, 18 November 2024. We visited areas relevant to each of the core services inspected and spoke with a number of staff members of various specialities and professions including the director of health and social services, chief medical officer, hospital manager, healthcare governance manager, MTO coordinator, a representative from the emotional wellbeing service, consultants, doctors, nurses, a pharmacist, ambulance driver, a GP, theatre manager, an anaesthetist, electrical and biomedical engineers, laboratory manager, and administrators, either in focus groups or individually. Following an invitation to all staff to attend individual drop-in sessions with an inspector to share their personal views, five individual meetings were requested and subsequently took place. Members of the public were invited to submit written feedback to an inspector, resulting in six responses, one of which was on behalf of a group of service

users, after which a public focus group meeting was convened at their request to further explore the issues that were raised by the group. We noted the electronic and patient record system and reviewed the quality management system and a range of documents including policies, procedures, committee agendas, minutes and terms of reference, staff survey results and incident report logs. We also spoke with the MoD, the Stephen Jaffray Memorial Fund and the Cancer Support Awareness Charity, each of which are stakeholders with whom the KEMH work closely.

3.5. Objectives of the external inspection

- To provide a comprehensive report of the findings of the inspectors for the use of KEMH senior management that can also be shared with politicians, other civil servants, and the public.
- To highlight areas of good practice where service provision may exceed that which might ordinarily be expected in such an environment.
- To present within the report recommendations of areas for locally achievable improvement with an indication of which may be considered more urgent in their nature, and which may be for further discussion or consideration.
- To focus the inspection on the following key services provided at the KEMH: emergency care (including ambulance and A&E), ward-based care, theatres and the process for medical treatment overseas. These areas were prioritised partly to ensure the scale of the inspection would be feasible, and because other services have been reviewed periodically by the MoD during quality assurances visits. While these were the focus areas, the inspection team were also able to include a review of services offered by pharmacy, the laboratory, a public health professional, and electro-biomedical engineering. Maternity services were not in scope, because an internal review was recently conducted and actions were underway, one of which was to commission an independent external review. An initial review in a specific case has already occurred, with plans for a wider review of the service more generally currently being planned for later in 2025.
- To apply the five guiding principles as adopted by the CQC to the agreed assessment framework, i.e., to consider whether the services are safe, effective, caring, responsive and well-led.
- Key lines of enquiry for each service area (where appropriate and applicable) were taken from the CQC. The relevant evidence in each case required further discussion, with consideration given to the operational environment of the Falkland Islands. In some cases, what constitutes suitable ‘evidence’ was discussed during the inspection itself.
- Data handling arrangements with the KEMH were requested to be assessed in all service areas of focus.

4. Our findings

4.1. Commendations

We found the following outstanding practice for which KEMH are to be commended:

- **Access:** The healthcare services inspected offered excellent access to service users, with minimal waiting times in the Emergency Department, low bed occupancy and clinic waiting times that are far lower than in the UK. Effective mechanisms were also in place for healthcare provision in remote areas of the Falkland Islands. Services were highly visible, as evidenced by the "open door" approach to the hospital ward areas.

- **Integrated healthcare system:** The integrated nature of primary and secondary care services "under one roof" facilitated close working and coordination between different service areas as well as facilitating efficiency and sustainability of service provision and resource utilisation, ensuring a high-quality patient experience due to having fewer points of contact and being able to receive timely support.

- **Range of services:** The range of services offered was impressive, given the context, which was made possible by clinical staff having a broader range of skills than would be typically seen within less remote settings, coupled with the use of an extensive programme of visiting specialists throughout the year which also offered an opportunity for further skills development of substantive staff.

- **Clinical care:** We found evidence of high quality and effective care, with no evidence to warrant serious safety concerns in the areas inspected. We identified safeguarding, emotional support services, palliative, end of life care, and care for people who require extra assistance as areas of particularly good practice; the latter being evidenced by the significant investment in the Tussac House residential development.

- **Support of clinical services:** The hospital housed its own diagnostics laboratory which offered a comprehensive range of appropriate tests, given the context, and had well developed quality and assurance processes. From our experience, the laboratory facility is highlighted is an example of best practice for other UKOTs to follow. In addition, the inspectors were impressed by the robust and high-quality services offered by the electro-biomedical engineers who maintained, serviced and repaired a large proportion of hospital equipment. We would like to highlight this approach to care of equipment as good practice that other UKOTs may wish to adopt.

- **People and culture:** We found evidence of a respectful and strong collegial culture among the hospital staff, who have a sense of belonging and care for each other, the hospital, and its patients. Staff provided a great deal of goodwill, often going above and beyond in their roles to support service delivery and each other. This finding is also supported somewhat by evidence

from last year's staff survey results in which 65% of respondents agreed or strongly agreed that they work in a respectful and supportive environment and 62% of respondents also agreed or strongly agreed that they gain satisfaction from their work, though there are areas that warrant further consideration in view of the neutral and negative responses, as discussed below.

- **Business continuity plan:** The hospital had a robust business continuity plan in place, in the event of material disruption to core services such as in the event of electrical failure, fire or flood. The plan was informed primarily by learning from previous experience including previous disruptions to the internet, fire and the COVID pandemic, and includes contingency for access to medical records, electric, water and space provision.

4.2. Recommendations

While we found no significant safety concerns in the areas that we investigated, areas for improvement and development were identified. We therefore provide the following recommendations that we would ask the Falkland Islands Government to consider endorsing:

1. **Review and develop the approach to quality oversight and governance:** While the HMSC framework enabled governance and oversight of key management and operational issues, we feel that there is scope to enhance quality oversight and governance and timely decision making by revising the terms of reference, taking account of membership, the role and function of the committee, meeting frequency, oversight of a broader range of governance issues including the KEMH risk register, which should be improved, and oversight of an action tracker. Related to this:

    1.1. Policies: We noted an absence of a policy on policies that we feel would be beneficial.

    1.2. Healthcare quality management: The hospital had a digital quality management system within which data was stored relating to a range of quality measures. The extent to which this is fully and consistently utilised by staff, however, was uncertain, particularly in terms of incident reporting. We recommend that that a mandatory training programme is established to familiarise staff with the software and to clarify expectations of how the software must be used. We also recommend extending the scope of data capture and analysis to identify trends and emerging risks, including the development of a planned annual cycle of audits across all services.

2. **Produce an overarching short, medium and long-term KEMH strategy:** While the hospital had a clear vision of its goals, a short-, medium- and long-term strategy to achieve them was lacking, which we feel would support with future-proofing services. Within the strategy, we suggest that KEHM should identify services and service developments that they would like to develop business cases for, and to consider the development timeline, in addition to stipulating which service developments are felt to be out of scope due to feasibility within the context of the Falkland Islands. We also recommend that specific strategies are considered for workforce development (i.e., recruitment, retention and training), and for development of the estate. In considering the recruitment strategy, we would encourage KEMH to pay particular attention to areas requiring additional resilience and to succession planning.

3. **Develop procedures and protocols for clinical services:** We recommend that where practically possible, procedures and protocols that draw on current evidence-based practice are developed or adopted from elsewhere to support new staff and integration within teams. Staff identified ward based general nursing and nursing care of paediatrics, in particular, as areas that may benefit from this approach. We would encourage clinical teams to identify and prioritise which interventions would be most appropriate to target, based on their experience of encountering differing approaches.

4. **Establish a programme of team meetings within clinical specialities:** Where they do not already take place, we recommend that a regular programme of discipline-specific team meetings is established as a forum for communicating and sharing responsibilities, goals, objectives, in addition to good – and new evidence-based - practice within teams.

5. **Confidentiality:** Significant improvements were made to internal processes and procedures around accessing patient data following the recent data breaches including, for example, introduction of tiered access levels according to job roles. However, there was a notable level of anxiety among staff who felt they may get in trouble for legitimately accessing patient records. In addition, feedback from the public and some staff members highlighted concerns about confidentiality within the hospital during consultations due to noise transfer between adjacent consulting areas that are separated only by a curtain. This, we understood, occurred in overspill accommodation, which requires further modification for its currently intended use, rather than in the main hospital building itself. Accordingly, we recommend that KEMH undertake a space utilisation survey and find a suitable solution to ensure patient confidentiality during consultations. As an overarching principle in relation to confidentiality, we recommend that KEMH continue to undertake a regular cycle of audits focused on information management and confidentiality, that should be subject to independent external review and reported on to the KEMH management board. Should assistance be required with sourcing an independent reviewer, please liaise with Prof Ian Cumming, UK Ambassador for Health to the Overseas Territories.

6. **Develop the complaints handling process:** Feedback from the public highlighted concerns regarding the complaints handling process which we further examined during our inspection. While complaints were acknowledged and addressed using appropriate processes, we feel there is scope to develop the approach to overseeing the quality of responses that are provided to patients and for developing the approach to how outcomes and learning are shared with relevant staff.

7. **Staff development and appraisals:** We found evidence that staff were encouraged to undertake additional training and development, but the approach to annual appraisals and the opportunity that provides to discuss development needs and opportunities, did not appear to be consistent across the hospital. We suggest that an annual cycle of appraisals should be established using a standardised process and proforma that is overseen centrally to ensure completion.

8. **Emergency services call handling:** Emergency services appeared to be highly responsive to needs, but that there were inefficiencies with the process. We recommend that KEMH liaise with the police department to develop an algorithm for call handling and triaging, which should also take account of only one of two ambulances being suitable for use on unsealed Falkland

Islands roads. For future developments, following installation of better internet connectivity, we also recommend incorporating the use of What3words / GoodSAMs into the response process.

9. **Major incident plan:** We note that the Falkland Islands Government and the MoD had a major incident plan, and that a recent major incident was managed well, but we feel that this was, in part, due to the chance availability of a visiting paramedic on scene, which is not a service currently offered by KEMH. Due to the context and scale of resources available, there is therefore likely to be a lack of resilience to manage major incidents, though it is worth noting that KEMH wouldn't have primacy at an MoD major incident on-scene. Nevertheless, we recommend that the KEMH major incident plan is reviewed to ensure that adequate resources can be deployed as required.

10. **Future reinspection of maternity services:** While maternity services were out of scope of this investigation, we recommend that KEMH conduct a follow-up service evaluation into these services before the end of 2025 to review progress against any association actions. We also recommend that KEMH produce a public communication about lessons learned and resulting actions that have been taken.

11. **Chronic disease management and prevention:** Every citizen in the Falkland Islands was registered in the same system which connects between general practice and the hospital system. This presents an excellent opportunity for the health service to consider the longitudinal care of the population in terms of secondary prevention such as long-term conditions. We encourage KEMH to consider how the role of the public health department could be evolved to make best use of this data to support a healthcare prevention programme.

12. **Electronic patient record keeping:** Whilst we didn't inspect the current Electronic Patient Record system in detail, we heard repeatedly that it is a relatively old server-based system that the software company are unable to fully maintain and update. This represents a clinical governance risk across multiple areas, such as clinical coding and drug formulary management. There is also a mixed economy of paper and electronic records, particularly in the in-patient areas. If possible, we recommend that KEMH looks to procure a single, integrated, electronic patient record system.

13. **Future perspectives (AI/Digital):** In view of developments around the use of artificial intelligence (AI) and digital technologies for healthcare, we recommend that KEMH consider how these could be incorporate to enhance the quality and efficiency of their services.

14. **Reinspection:** Since this was the first full inspection of KEMH in over 10 years, we recommend that a repeat inspection is conducted in approximately 2 years to review programmes and to inspect areas that were out of scope of this inspection, including the general practice provision.

5. Is the organisation well-led?

Our overall assessment is that the hospital was well-led.

- Leaders possessed the expertise, capacity, and capability to ensure that strategies were implemented, and performance risks were managed.
- The hospital leaders were well-versed in issues and priorities related to service quality and sustainability and understood the challenges and were addressing them accordingly.
- The hospital had a clear vision of its goals.
- Leaders and staff engaged with patients, staff, the public, and local organisations to plan and manage services, including collaboration with partners to support and enhance patient care.
- Financial governance processes were robust, with oversight provided by an established Senior Management Team (SMT) group at the hospital reporting to the Health and Medical Services Committee (HMSC)
- The SMT consistently demonstrated integrity. Staff representatives viewed the senior team as approachable, attentive to front-line staff, and responsive to concerns.

<u>However</u>

- While the hospital had a clear vision of its goals, a short-, medium- and long-term strategy to achieve them is lacking.
- The terms of reference for HMSC were not ideally placed to fully support SMT in terms of timely decision making in respect of policy.
- The hospital gathered and analysed data, enabling staff to understand performance, but we feel there is scope to improve the quantity and quality of data that is collected and how it is analysed and shared with staff and overseen by HMSC.
- All staff that we spoke to were dedicated to continuous learning and service improvement, but the approach to continued professional development and appraisal is not formalised.
- Governance processes were in place to identify issues and act locally, but there is a need to formalise these to provide a greater level of assurance. A greater level of reporting to - and oversight by - HMSC would provide additional support for SMT to recognise risks and take action to implement timely and sustainable changes.
- While we were reassured that appropriate policies are in place, we feel that there is scope to develop processes to provide assurance that they are being followed, including, for example, the approach to maintaining and overseeing a risk-register, as discussed in more detail in section 5.5.

Specific detail relating leadership themes is discussed in the following sections in the context of the hospital as a whole organisation, rather than by service area, due to the relatively small size and scope of services offered, and because many of the key principles apply across the organisation.

5.1. Leadership

Hospital leaders had the experience, capacity, and capability to ensure that strategies could be delivered and risks to performance addressed. Hospital leaders were knowledgeable about issues and priorities for the quality and sustainability of services, understood what challenges exist and acted to address them. The Senior Management Team was cohesive, had the appropriate range of skills, knowledge and experience to perform its role, and members were able to challenge appropriately. Senior leaders consistently demonstrated integrity and were deemed highly approachable and attentive to front-line staff.

All roles within the senior leadership team were substantive which offers stability in the team. The leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. We consistently heard very positive staff reflections of their confidence in the Director of Health and Social Services.

We found there was a good balance of approach and expertise between the director of health and social services and the chief medical officer (CMO). Each understood the boundaries of their roles, though were equally clear how to maximise the impact of their roles. The CMO carries a high degree of day-to-day operational responsibility without a nominated deputy or dedicated administrative support, however, which presents a risk in terms of resilience in case of absence or unavailability.

There were effective systems in place to ensure that people were fit for the role that they were employed for. All qualified staff working for the hospital were required to be registered with the appropriate UK professional body or recognised international equivalent. As far as possible, the hospital sought to employ staff who were familiar with the professional culture and approaches of the UK NHS so that they could be assimilated easily into hospital teams. All posts in the KEMH were regarded as sensitive and subject to enhanced checks. When staff were recruited from the UK it involved the Acro system, rather than DBS, unless via a UK-based agency. All doctors were interviewed over Teams, but we noted, however, that KEMH were not involved in selection process for recruitment of surgeons and anaesthetists, instead relying on agency selection which may present challenges in terms of ensuring appropriate fit for the organisation. In addition, the human resources function sat within the Falkland Islands Government (FIG) and was part of business support to the hospital. This appears to be somewhat remote and perhaps not as effective as it might be. Examples where effectiveness could be improved include clarity on appraisal rates, mandatory training rates, and exit interviews.

5.2. Vision and strategy

The hospital had a vision for what it wanted to achieve but a strategy to turn it into action was lacking. The vision was focused on both immediate priorities and sustainability of services and referred to working with partners to improve patient pathways.

We were pleased to note that the hospital together the FIG has made strides towards future-proofing development of some services and development of the estate, including a commitment to installing a 'Starlink' internet connection, procurement of a new electronic patient records system, and the major investment into the Tussac House residential development. In addition, the CMO was thoughtful about certain future medical developments. For example, the extent to which the anti-obesity drugs known as GLP-1 receptor agonists should be made available in the absence of a full weight-loss

pathway. Other considerations noted include the possibility of extending chemotherapy services, acquiring an MRI scanner and introducing renal dialysis. It was unclear what mechanisms were in place for prioritisation and decision making in this regard, especially in the absence of a formal health needs assessment of the population. While the SMT had a vision for future developments, an overarching short-, medium- and long-term strategy was lacking. It would be useful, for example, to identify services and service developments that they would like to develop business cases for, which may include diversification of MTO and development of an in-country air ambulance service, and to consider the development timeline, in addition to stipulating which service developments are felt to be out of scope due to feasibility within the context of the Falkland Islands.

There were 215 staff in the Directorate and a vacancy rate of approximately 25% which included newly created posts for Tussac House which had only recently commenced recruitment. Within KEMH, 122 posts existed including facilities posts, of which there were 18.5 vacancies, including vacancies that had been appointed to, but post-holder hasn't yet started. Nursing and medical locums were sourced through an agency based in the UK called 'Dedicare', with whom the Falkland Islands have a long relationship. 'Dedicare' acts as the designated body for doctors who are engaged through them and are considered to offer a high-quality service. While the hospital leaders were aware of challenges associated with workforce recruitment and retention, a formally documented strategy was lacking. Concerns were raised during our visit by KEMH senior leadership and some staff about workforce shortages in respect of many vacant posts, largely due to the challenges of recruiting staff to the Falkland Islands. During our discussions with the director of health of social services, we explored alternative job advertisement platforms and the potential to create links with overseas recruitment agencies, such as Overseas Development and Employment Promotion Consultants (ODEPC). In addition, staff retention in some areas was problematic for a variety of reasons including non-competitive pay compared particularly to the UK, challenges around higher education provision for those with non-Falkland Islands status, and Falklands work not being recognised on the NHS Performers List for the purpose of Revalidation. From our investigation, particular areas that would benefit from consideration within a workforce strategy are broadening the skills mix in nursing, introduction of a stand-alone obstetrician (rather than a GP-led service), a paramedic / paramedic technician service (further details about this are discussed below), developing pharmacy capacity and creating resilience around anaesthetic services and healthcare governance.

Similarly, senior leaders were aware of some key issues relating to the estate that require addressing but noted some challenges with progressing these and a formally documented plan was lacking. Issues that we agree should be rectified urgently include the need to identify and remove unused water pipes, and challenges with the sewage system. Some of the infrastructure also posed challenges in terms of maintaining confidentiality due to overspill accommodation. We learned, for example, of references to curtains not providing confidentiality and certain spaces, including Pharmacy, being very cramped. In addition, senior leaders and staff identified other physical and technological infrastructure improvements that are required including the installation of a new electronic patient record system, showering facilities, a separate clean and dirty area within the ward, and a door within the theatre that should be replaced with a different format according to best practice, and a larger plaster room. Theatre and ward staff that we spoke to also highlighted potential to redesign the layout of the estate to allow for future development of services.

5.3. Culture

Staff were focused on the needs of patients receiving care. In general, staff reported feeling respected, supported and valued at work, though some highlighted the need for better communication within teams. Staff were dedicated to continuous learning and service improvement, but the approach to their own continued professional development and appraisal was not formalised. The hospital promoted an open culture where patients, their families and staff could raise concerns. Some staff, however, felt anxious about the implications of recent patient complaints which impacted on daily working practices.

We found evidence of a strong collegial culture among the hospital staff, who had a sense of belonging and care for each other, the hospital, and its patients. Staff provided a great deal of goodwill, often going above and beyond in their roles to support service delivery and each other. This finding is also supported, in part, by evidence from the FIG-wide staff survey results in late 2023 in which 65% of respondents agreed or strongly agreed that they work in a respectful and supportive environment and 62% of respondents also agreed or strongly agreed that they gain satisfaction from their work. The same staff survey also identified that 54% of respondents were somewhat or very satisfied about communication within their team, while 38% of respondents agreed that responsibilities, goals, objectives are clearly communicated. Further exploration of these findings with staff revealed opportunities to strengthen communication and sharing of responsibilities, goals, objectives, in addition to good – and new evidence-based - practice within teams via discipline-specific team meetings.

All doctors were advanced life support (ALS) trained, which was mandatory, and ideally advanced trauma life support (ATLS) trained. KEMH paid for ATLS training and ran a course in-house. The hospital believed that everyone had received this training but accepted that records were lacking. There was only one doctor on the island who was not on the GMC Register, and we were informed that this doctor had received annual appraisal on site. While the 2023 staff survey demonstrated that 84% of staff were either neutral, satisfied or very satisfied that they were encouraged to undertake additional training and development, 46% of staff felt that their manager talked to them seldom or not at all about career development and 49% of staff reported seldom or never receiving supportive feedback on their work. During the inspection, staff mentioned a lack of formalised approach to annual appraisals, during which they would expect career development and performance feedback to be discussed. We were informed that while mandatory training and appraisal rates were not known across KEMH, though plans were in place to audit training rates in January 2025. There was a perception that training levels were acceptable, but appraisal rates being less so. Personal files were kept on a 'Y' drive and so these could be manually interrogated for appraisal and training evidence within each file, though this was time intensive. On checking one nurses' file, there was no recording of an appraisal. For registered nurses, access to the portfolio is essential for revalidation, and the hospital were not confident that this is reliably recorded in the electronic system that houses training data. The exception to this was that almost all locum doctors come through an agency called 'Dedicare'. It can therefore appraise the doctors for whom it is their Designated Body and deal directly with the GMC in matters that relate to them, including recommendation for Revalidation.

We understood that the 2023 staff survey was the first such survey in some time and that another was underway during the period of the inspection. We would encourage FIG to continue to undertake these annually, to share findings with staff and to engage staff in an open forum to discuss the results.

5.4. Governance

Financial governance processes were robust, with oversight provided by SMT who report to HMSC. The governance and management of partnerships and joint working arrangements were also clearly set out, understood and effective. While we were reassured by what we found, the structure, processes and systems in place to provide assurance of quality oversight and broader governance issues were less effective. Staff were, however, generally clear about their roles and accountabilities within the context of the existing governance framework.

The hospital employed a healthcare governance manager who worked at KEMH since 1985, and previously as a quality manager for a hospital in the UK. A data system administrator was in place, though there was a recognised fragility of the 'team', particularly in view of there being no clear succession plan.

Unlike hospitals within the UK, the Falkland Islands did not have a hospital board; instead, the SMT reported to the Health and Medical Services Committee (HMSC) which sat outside of the health and social services directorate and was chaired by an elected MLA. HMSC met quarterly and received updates from the director of health and social services, on behalf of SMT, on matters including operational and financial details, ongoing projects, and high-level data reports on service level objectives, appointments, compliments and complaints, and incidents. While this framework enabled oversight of key management and operational issues, we feel that the HMSC terms of reference should be revised to provide greater oversight and accountability for quality assurance and governance purposes within KEMH and to support agile and timely decision making at KEMH in respect of policy development and other such matters that would benefit from early intervention. Noting that it may not be feasible for HMSC to be chaired by an MLA with experience of working in the health and care sector, we feel that the committee membership would benefit from a greater level of representation from the healthcare sector. Aligned to this, we found scope for delegation of some authority from HMSC to the SMT in respect of low and medium level policy developments and any other such matters deemed appropriate by the director of health and social services, who in turn could report a decision log to HMSC.

We reviewed a number of policies throughout the inspection and are satisfied that they were fit for purpose, stored appropriately with an audit trail, and subject to review. We noted, however, an absence of a policy on policies, which we feel would be beneficial, following revision of the HMSC terms of reference, to outline the approach to development, ownership, oversight, revision and approval of all policies within the hospital.

5.5. Management of risk, issues and performance

Leaders and teams used systems to manage performance and kept a live risk register, though the reliability of the register is uncertain. The extent to which the healthcare quality management system is fully and consistently utilised is also uncertain. The hospital had plans to cope with unexpected events, though there is a relatively low level of resilience at KEMH in the event of a major incident.

The hospital had a robust business continuity plan in place, in the event of material disruption to core services such as in the event of electrical failure, fire or flood. The plan was informed primarily by learning from previous experience including previous disruptions to the internet, fire and the COVID

pandemic, and includes contingency for access to paper-based medical records, electric, water and space provision at identified locations.

We also noted that the FIG has a major incident plan, and that a recent major incident was managed well, but we feel that this was, in part, due to the chance availability on scene of a visiting paramedic. Due to the context of the Falkland Islands and the scale of resources available, there is likely to be a lack of resilience to manage major incidents. We have therefore recommended that the major incident plan is reviewed to ensure that adequate resources can be deployed as required, including, for example, sufficient analgesia and potentially, paramedic services.

The hospital gathered and analysed data on a risk register that sits in an Excel 2019 spreadsheet. Every department had a live tab, which was a standard mechanism across FIG. The risk register operated on a 4 x 4 matrix, with the maximum risk scoring of 16. On our viewing of the register, it was difficult to see whether risks were updated, and the difference between initial risks and controlled/residual risks was unclear. At the time of the inspection, there appeared to be 10 risks at 16 (i.e., catastrophic consequences and highly likely/inevitable), though we understood that after moderation, this was later reduced to one risk scored at 16 which would be reported up. The healthcare governance manager was not aware that FIG operates with a broad assessment framework, and we see no reason for KEMH to adopt one unless FIG does. The use of the risk register in the format we viewed, however, appears to be unreliable. In addition, there is a need to formalise the approach to provide a greater level of assurance that risk is being appropriately overseen and managed. To enable closer oversight of – and ability to respond quickly to – emerging and existing risks at KEMH, we feel it would be beneficial for HMSC to meet more frequently, and to receive for discussion and oversight regular reports from KEMH on a planned annual cycle of clinical audits and service evaluations and the outcomes thereof, and prescriptions made, in addition to currently reported information within the governance section of the Director's report. We also suggest that the risk-register produced by KEMH should be overseen by HMSC, along with an associated action log to oversee risks associated with themes arising from incidents, complaints, audits and service evaluations, in addition to operational matters such as infrastructure, resources and finance.

A digital quality management system called 'Q-Pulse' was in place within which policies were stored, together with data relating to training and a range of quality measures, including incidents, and feedback received as compliments and complaints. This has been in place since 2019 and so was well established, though it is not on the NHS Framework. Incidents can be logged electronically from anywhere in the health system and are collated and investigated by the healthcare governance manager. This system was used by the laboratories and the rest of the service chose to use Q-Pulse on this basis. The healthcare governance manager was responsible for completing all incident reports and producing a quarterly report to HMSC to summarise levels of harm. Q-Pulse was available to all staff, though the extent to which Q-Pulse was fully and consistently utilised by staff for logging incidents and interacting with the complaints process was uncertain. The healthcare governance manager expressed some concern that incident reporting was not undertaken widely, despite their encouragement, and within the system there was inconsistent and unreliable consideration of possible harm caused. We too noted hesitancy among some staff that we spoke to in terms of the perceived accessibility of the software. We were advised that staff receive training for use of Q-Pulse during induction, but this was not explicitly specified within the hospital's mandatory training policy. In addition, staff reported that they would benefit from greater clarity around the criteria for significant events and accidents. A mandatory training policy was introduced in December 2023 which outlined mandatory training requirements, dependent on job role, and the responsibilities for line managers to ensure implementation and monitoring, with ultimate responsibility for monitoring compliance sitting

with the director of health and social services. While a consistent approach to annual appraisals was lacking, we understood that plans were in place to monitor compliance with mandatory training using QPulse.

A particular risk that was identified came from feedback from the public and some staff members who highlighted concerns about confidentiality within the hospital during consultations, resulting from the separation of consultation areas with a curtain that didn't adequately protect against noise transfer. In some examples, the consultation areas were used for quite different purposes, due to overspill accommodation, during which, sensitive information was discussed and sometimes overhead in the adjacent area.

5.6. Information management

The hospital collected data and analysed it, though there is scope to extend the quantity and quality of data capture to allow for more robust analysis, including longitudinally. Staff were able to access data to understand performance, make decisions and improvements. The information systems were integrated and secure, but some staff felt anxious about accessing healthcare information due to recent data breaches. Data were submitted to HMSC for review.

There was a strong ambition to improve existing platforms and develop new ones to support efficient pathways and delivery of patient care in particular electronic patient records. There were arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The CMO was the Caldicott Guardian, and the Caldicott principles were in mandatory training and the confidentiality policy.

Every citizen in the Falkland Islands was registered on the same clinical system: EMIS PCS. This was an old server-based system, running on Windows 7, and approaching obsolescence as EMIS are moving entirely to cloud-based EPRs. The director of health and social services was in active discussion with EMIS about a successor EPR which would hopefully also offer some facility for hospital-based services including the ward. The ward relied on paper records, though hospital staff could access EMIS PCS records from terminals across the site. Moving from a server-based system was considered impractical until recently as the internet access available to the medical system was slow and with limited bandwidth. There is now a real possibility of the island accessing satellite internet via 'Starlink', which opens the possibility of cloud-based systems.

The hospital had a supply of data with an effective quality management electronic system to support this, which included a separate system, Dynamics, to monitor financial performance. Reporting included a range of performance indicators including service level objectives, appointments and non-attendance, complaints, compliments, incidents, activity data from MTO, casualty and imaging, policies and procedures and staff training. In addition, however, we feel it would be useful for the hospital to report regularly on the medicines prescribed to allow for more proactive analysis of trends and any emerging risks in that regard (e.g., monitoring risk of polypharmacy), and to plan and initiate a regular cycle of clinical audits across all services. To further support quality assurance, we would suggest undertaking statistical process control analysis of data from these reports to identify special cause variation, and to report the findings to HMSC.

Information governance and confidentiality were clearly areas of great concern to the public and to staff (who are all patients of the single system). In particular, the well-publicised data breaches that

were the subject of court proceedings in 2021 and 2023 resulted in patient records being accessed by two previous employees, which was a significant concern of some members of the public who we spoke to. The hospital has since strengthened internal processes and procedures around accessing patient data which we found evidence for, including the process for requesting and being granted access rights, training and signing of a confidentiality agreement which is required to be completed as part of the induction process, introduction of mandatory training on governance, a long-standing policy on confidentiality that was recently reviewed, spot checks, and introduction of an auditable process. We were advised that patient notes were sometimes visible on the nurses' station in the ward, laid out ahead of day case lists, and DNACPR forms being moved around the system. We also witnessed medical records being visible on the nurses' station during our inspection. The healthcare governance manager undertook induction for all staff and followed an induction checklist which was signed off on completion. Within the information governance section, line managers identified the level of appropriate access to the electronic patient record and other data sources. We are satisfied that these interventions significantly minimise the risk of deliberate, inappropriate access to medical records and enhance the ability to detect breaches quickly should they occur. We noted anxiety among staff, however, who felt they may get in trouble for legitimately accessing patient records, which in turn could compromise patient care. Introduction of a new patient record system following the forthcoming establishment of improved internet access provides an excellent opportunity to review and further strengthen data security.

Since every citizen in the Falkland Islands was registered in the same electronic patient system which connects between general practice and the hospital system, an excellent opportunity exists for the health service to consider the longitudinal care of the population. This could, in part, be achieved by developing the role of the public health department to make best use of this data to support a secondary healthcare prevention programme for long-term conditions. In addition, the hospital compiled a database of patients who were deemed to be of increased vulnerability during COVID which they have since maintained, which represents good practise and could also be of utility for such an intervention.

In view of developments around the use of artificial intelligence and digital technologies for healthcare, there are also future opportunities to consider how these developments could be incorporate to enhance the quality and efficiency of their services including, for example, with diagnostic imaging.

5.7. Engagement

Leaders and staff engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to deliver and help improve services for patients.

Patients, carers and service users were able to provide feedback to the hospital via the compliments and complaints process and were offered the opportunity to meet with senior leaders to discuss the outcome if they were unsatisfied. Upon review of reports submitted to HMSC and review of the healthcare quality management system, we noted a relatively balanced volume of compliments and complaints regarding individual episodes of care or more general issues. Feedback from the public, however, highlighted concerns regarding the complaints handling process which we further examined during our inspection. The healthcare governance manager handled all complaints, which were logged into the Q-Pulse System. Departmental managers were asked to investigate the complaints

and to provide a report, which was then signed off by the healthcare governance manager. If there was an escalation, for whatever reason, these were passed to either the hospital manager or the director of health and social services. While complaints were acknowledged and addressed using appropriate processes, we feel there is scope to improve the approach to overseeing and developing the quality of responses. This could include, for example, a standard operating procedure to require that responses to complaints in the top two tiers of significance are signed off by a member of the hospital senior management, and for how the outcomes are shared with staff.

Ad-hoc patient and service user engagement was undertaken for particular issues, including, for example, the "Meals on Wheels" service which was commissioned as a result of staff feedback highlighting potential issues with the service. Formal public consultation took place when there was planned legislative change; an example of which was for policy that will form the basis for new legislation relating to mental capacity and the introduction of advance decisions around treatment, in addition to other new legal mechanisms. Reflecting on issues raised in public feedback, however, we encourage KEMH to consider their approach to public engagement to build trust and provide reassurance, where appropriate, that appropriate measures are being taken to address concerns and issues that arise.

The senior leadership team recognised the importance of wider partnership working to secure sustainability of clinical services, including their work with the police, fire and rescue service, the MoD, the Stephen Jaffray Memorial Fund, and the Cancer Support Awareness Charity.

In the summer months, the population of the Falkland Islands increases substantially with the arrival of cruise ships bringing day tourists into Stanley. In post-Covid times there were difficulties managing the influx of quite poorly and frail patients whom the ships would like to offload. The Chief Medical Officer had spent time meeting with the local agents of cruise ship companies to clarify that passengers should not be off-loaded on the Falkland Islands' health facilities unless in acute emergency.

While the hospital had engaged staff, feedback suggests that staff would prefer a structured and systematic approach to this, particularly in terms of communicating changes and developments.

5.8. Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. A budget was made available for continued professional development (CPD) and staff teams took initiative in identifying CPD priorities. However, a systematic approach to undertaking clinical audits was lacking and the ways in which learning was disseminated and acted upon from data analysis relating to healthcare quality was sometimes unclear.

The hospital provided training and development opportunities for local and international staff. Training included Immediate Life Support (ILS) courses, a local version of the Advanced Trauma Life Support (ATLS) course, and suicide and self-harm awareness training (STORM), offered by accredited trainers. They also had a National Vocational Qualification (NVQ) programme, and a number of healthcare and social work assistants have achieved NVQs at levels 2 and 3.

The service was transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the

population to design improvements to meet them. An example of this is that MoD were invited to attend HMSC meetings and to attend joint training sessions with KEMH staff.

Leaders were able to demonstrate learning from safeguarding reviews, incidents and complaints to improve patient practice, though it was unclear how learning from these was disseminated more broadly across the hospital. The hospital had undertaken a series of audits, though these were not formally scheduled across all areas in a systematic way. A substantive employee evidently undertook some audits on EMIS that would be recognisable as a form of the Quality and Outcomes Framework (QOF) used in the UK, but it was unclear how they were disseminated or used. Similarly, feedback from staff highlighted scope to develop the approach to how outcomes and learning from patient and staff complaints, concerns, incidents and accidents are shared with relevant staff. In view of this, it would be beneficial to identify training opportunities for those leading on root cause analysis investigations to ensure incidents are investigated thoroughly and actions identified.

We heard from staff about service improvement projects that they were supported to take initiative on to improve patient care and outcomes, access and efficiency of service. Although not required to do so, there was also evidence of taking part in an accreditation scheme within the laboratory. In a resource constrained environment in terms of staff capacity, undertaking of formal service evaluations was, understandably, challenging to accommodate, though the hospital would be encouraged to consider how this could be supported as a recognised CPD activity.
Unanticipated deaths were dealt with by the coroner, and as such, we were unable to ascertain whether they were subject to timely review and whether appropriate issues were raised and disclosed when required, and learning shared with the hospital.

There is a system for Morbidity and Mortality (M&M) Reviews led by the consultant anaesthetists. We observed a well-attended multi-disciplinary M&M Meeting with good discussion and learning.

Noting the relatively high level of staff turnover due to the context of working in the Falklands and dependency on agency workers and visiting specialists, there was a possibility that the approach to certain clinical practices varied depending on the country and parameters that staff have previously worked in. While this did not present us with concern about the safety or effectiveness of care, we feel that there is scope to standardise the approach to clinical practice by developing or adopting from elsewhere procedures and protocols that draw on current evidence-based practice for use within teams. Particular areas that are felt would benefit from this, as identified by the staff we spoke to, are general nursing and nursing care of paediatrics, though these are not exhaustive suggestions. In turn, this will support with on-boarding of new staff into teams, provide clarity for the purpose of clinical audit and service evaluation data analysis, and enable greater opportunity to refine, develop and retain knowledge of new skills learned from visiting specialists.

Inpatients were given the opportunity to complete satisfaction surveys; in the last quarter of 2023/24, inpatient satisfaction was reported to be 100%. We feel, however, that there is scope to broaden satisfaction surveys to include outpatients.

6. Emergency care (including ambulance and A&E)

6.1. Description of the service

Accident and emergency (A&E) is a nurse-led service with two rotating nurses at the time of inspection, one of whom oversees the ward, and a third, vacant post. The emergency department is staffed from 8.30am to 4.30pm Mon-Fri. An on-call service covers times outside of this, with an assigned nurse being on-call. A doctor on-call for the day oversees operations from a medical perspective. The service is available to everyone within the Falkland Islands, although charges may apply for non-permanent residents.

For out-of-hours care, the ward operates the first point of contact triage, either by phone or face-to-face, with service users being able to arrive in person without having made previous contact. The main entrance is locked from 10pm, so patients must ring for attention. At other times they can just walk onto the ward.

The ambulance service is part of the A&E department, rather than it being a separate function. It typically deploys with a driver plus on-call nurse to deliver an "on-scene" response. In certain circumstances, including for major incidents, a doctor may also be deployed. There are two ambulances available; both are converted Mercedes based on a UK specification, but only one of which has winter tyres. There is also an ambulance driver on-site 24/7.

Emergency care activity ranges from major trauma, medical emergencies including, for example, myocardial infarction and stroke, down to minor ailments and illnesses including dressing changes and managing issues within the home such as falls, in addition to a "walk-in" service. It is therefore difficult to compare the service directly with a UK A&E service.

The workload is very variable and dependent on seasonal variation and GP availability, whereby reduced GP availability often results in an increased A&E workload. There is a much higher workload during fishing and tourist season, which sees an excess of 70,000-day visitors from cruise ships to the Falkland Islands per year during the summer season.

There is no formal establishment of staff for A&E services per se; all workforce roles that jointly make up the service are linked to other departments. Ambulance drivers, for example, also have other driving and general security duties.

6.2. The safety of the service

We feel that the service, under typical circumstances, was safe. Patients underwent thorough assessments, timely treatment, and there was evidence of clear communication between staff, appropriate infection control practices and appropriate and readily available emergency equipment and medication.

Due to the context and scale of resources available, resilience was low in terms of the ability to manage significant surges in workload, particularly in the context of a major incident, as discussed above. We recommend that the major incident plan is reviewed to ensure that adequate resources can be deployed as required, including, for example, sufficient analgesia.

6.3. The effectiveness of the service

We were reassured by what we reviewed that the service was effective overall; a triage system was in place, patients underwent quick assessment with clear communication, pain management appeared to be appropriate, an efficient workflow existed and there was collaboration with other services. During our inspection we witnessed an ambulance being called to the nearby hotel. The ambulance arrived within 5 minutes and the patient was competently assessed by a staff nurse, prior to immediate transfer to the hospital. The patient was able to walk to the ambulance; in contrast, we assume within the UK that they would have been placed in a seat. In the emergency department, the patient was handed over and assessed immediately by a nurse. They had IV access established and bloods taken, and in accordance with their symptoms a CT scan was urgently requested, and this took place within 20 minutes. There was a short delay - perhaps 30 mins - while the scan was interpreted and reported back in the UK, as is standard practice under an established contract with the UK. The patient was then admitted to the ward and had immediate appropriate treatment. The patient was seen quickly by a doctor who took a relevant history, confirmed the diagnosis and clarified the treatment regimen.

When on the ward we observed good, comprehensive, handover between nurses at the change of shift and well-ordered drug cupboards and Controlled Drug books. All drugs on the ward were in date and there was an effective system for stock control.

6.4. How caring the service is

We believe the service was caring and attentive, based on patient feedback, our discussions with staff and based on the incident described above that we witnessed. As one of only two patients on the ward, the nurse-to-patient ratio was therefore exceptional. We heard multiple examples of discretionary activity where nursing colleagues had gone the extra mile, within their professional competencies, to tailor care to a patient's or family's needs.

One piece of public feedback we received mentioned dissatisfaction with emergency care, though it was not furnished with specific detail, so we are unable to comment further.

6.5. The responsiveness of the service

The hospital's call-out policy covers ambulance deployment, as well as other assets which are available within the Falkland Islands to respond to emergencies including a search and rescue helicopter and government air service. Ambulance drivers are trained to First Response Emergency Care (FREC) level 3 to assist the nurse on scene, if necessary, with some drivers additionally trained to FREC-4 level.

We found that the emergency services were highly responsive to needs and that there was excellent communication and collaboration between the hospital teams, FIG emergency services and the MoD. This is particularly important given the remoteness of some areas of the Falkland Islands, for which MoD support was sometimes sought for emergencies. We understood, for example, that incidents

that occurred from beyond the quarry were first discussed with the CMO to determine whether KEMH or the MoD would be best placed to respond, in view of the subsequent risk to KEMH if limited staff resources are deployed away from the hospital. During a meeting with members of the MoD medical team, including the squadron leader, medical lead and a GP, a concern was raised in relation to emergency transfers from the MoD base or that side of the Falkland Islands to KEMH at Stanley. The military ambulances were not well suited to transfers to Stanley and there appeared to be difficulty in getting KEMH ambulances to travel to that part of the Falkland Islands. The base personnel helped where they can in civilian cases nearby, including, for example, having attended and managed a road traffic accident at Goose Green.

There may at times, however, have been inefficiencies with the call-out process. The police department received all initial emergency calls for triage which may have led to delays, cautionary overuse of resources that were deployed, and a lack of clarity around the nature of the situation. We understood that the nursing team were planning to liaise with the police department to develop an algorithm for call handling and triaging which we feel is a very sensible approach.

For future developments, following installation of better internet connectivity, we also recommend incorporating the use of What3words into the response process to assist with timely location of incidents, and to consider the introduction of GoodSAMs signposting to provide additional or potentially, alternative sources of support for the public and patients. To further support with pre-hospital care, particularly considering the remoteness of some residents, some staff pointed out an opportunity for training members of the public to become “first responders” across the Islands.

In terms of in-hospital emergency care, we witnessed highly responsive care during the incident described in section 6.5. Concerns were raised in public feedback, however, about a perceived lack of responsiveness on occasion to emergencies involving seafarers. Due to the nature of their activities, accidents are often severe and happen out-of-hours, and while a doctor is always on call 24/7, it was felt that care was sometimes delayed until working hours due to there not always being a doctor present in the building.

6.6. How well led the service is

Emergency care was underpinned with consistent protocols followed by all providers and effective communication between dispatch, ambulance crews, and receiving hospitals. We did, however, identify areas for future development to improve resilience and responsiveness of pre-hospital care:

In section 5.5. above, we discussed the potential benefit of a new paramedic service in the context of supporting the response to major incidents. In addition, we and a range of staff that we spoke to across different services, including the MoD, strongly feel that establishing a paramedic service would provide a much greater level of resilience for the emergency response team. It is anticipated that a large proportion of callouts could be managed by a paramedic, in turn reducing the requirement for a nurse and / or GP led response and thereby lowering operation risk within the service at KEMH that would otherwise occur if staff resources were reduced. It is important to note that many callouts are not simply medical / clinical emergencies; instead, emergency services are often called for incidents that can be managed within the home as a first response including, for examples, falls, emotional and wellbeing support, or other matters that can be deferred and referred to an appropriate service later. The role of a paramedic is wide-ranging, and they are well trained, well-equipped and experienced to manage various emergency situations, as well as situations that do not require a nurse or doctor. In addition, they would be very well placed to provide training to KEMH staff and to support with

upskilling other roles including, for example, the ambulance drivers, who may wish to become paramedic technicians.

We noted that there are no patient group directions (PGDs) in place at the hospital due to the absence of a legal framework in the Falkland Islands to underpin them. PGDs are written instructions that allow certain registered health professionals to administer medicines to patients without a prescription. We feel this is arguably relevant in other services in view of small staff base, but particularly so for pre-hospital care in remote regions, in both ordinary circumstances and for major incidents.

While excellent working arrangements were in place between the hospital teams, FIG emergency services and the MoD, it was unclear whether a standard process exists for a joint debrief and incident review with the MoD following the response to joint handling of major incidents and emergencies.

7. Ward-based care

7.1. Description of the service

The ward comprises of a 24-bed facility which included two intensive care unit beds and one maternity bed. There is also one bed that is a secure space for psychiatric inpatients, though we understood that the door requires further work before the room can be fully utilised. The ward provides secondary care to all residents of the Falkland Islands, including visitors and MoD personnel, as per the MoU. Included within service is maternity, and two dual-qualified nurses/ midwives. The ward operates first point of contact for triage, by phone and face to face outside of normal working hours. A diverse range of activities are provided on account of being the only secondary care facility on the Falkland Islands, and accordingly, ward staff have a broad skills mix. The ward staff comprises of a ward manager, a ward sister, two dual-qualified midwives/ nurses and 14 registered nurses, with three rotating into the emergency department. In terms of medical establishment, there were six full time equivalent positions for doctors, including the chief medical officer. These were staffed by a mixture of permanent staff and locum backfill.

In primary care, there was one practice nurse and one advanced nurse practitioner, and in community support there were four nurses, with two vacancies. The 0-19 service have one health visitor and one school nurse.
The emotional well-being service has three community psychiatric nurses.

A comprehensive programme of specialist visitors was in place throughout the year which sometimes resulted in pinch-points of activity, though this is to be expected in view of the relatively small staffing base.

7.2. The safety of the service

The ward was well equipped and appropriated measures were in place to ensure cleanliness, with stringent infection prevention control standards which were monitored by the infection control committee. The drug stock cupboard was well ordered and use by dates clearly marked. The system for the controlled drugs appeared secure, including stock control and reconciliation.

Remarkably, from a UK acute hospital perspective, there were no hospital acquired pressure ulcers or falls leading to injury to report from the previous year. The explanation is the high nurse to patient ratio and the fact that rehabilitation can largely take place outside of the hospital ward. There was therefore good 'discharge to assess' in place and there appeared to be a good amount of community support and intermediate care beds outside of KEMH.

Incidents were reported on Q-Pulse, but there was a feeling among some staff that the system is not intuitive and consequently, reporting levels are rather low.

7.3. The effectiveness of the service

The team knew each other well and felt that this was a contributing factor to their autonomy. Staff were flexible, and generally had a broader skill mix than a typical, larger hospital in the UK, but were aware of their own limitations and of not working beyond their scope of practice.

While ward staff could administer medications in acute settings, PGDs were not in place, as described in section 6.6., above.

During our visit, an inspector joined a ward handover at 07:30, which started promptly, was well attended and contained a concise review of patients on the ward and seen overnight. It then went on to cover upcoming business of the day, including planned discharges and patients attending for procedures.

7.4. How caring the service is

The size of the population meant that good person-centred care was possible, and public feedback that we received mentioned brilliant care from a nurse practitioner. We were particularly impressed with the permanent emergency department nurse who was very experienced and competent.

The handover we observed acted as an informal team meeting which, for the scale of the organisation, appeared to be fit for purpose. In addition, ward staff were very mindful of conducting debriefs and multidisciplinary team (MDT) meetings.

Medical notes were kept in A4 folders. They were identifiable by bed rather than patient name, which was a considered response to previous concerns about confidentiality. We did not look inside any clinical records or look in detail at any individual cases.

7.5. The responsiveness of the service

The small cadre of experienced registered nurses worked well together, and we were impressed with how they dealt with whatever the circumstance required – from mental health crises to general ward

work to critical care nursing. The ward previously had a visiting voluntary paramedic which staff reported to have found really helpful.

If there is a large cruise ship visiting on a weekend, the ward planned their workload accordingly.

7.6. How well led the service is

We found evidence of a well-led ward, including open communication, staff support, and collaboration with other departments. However, we noted areas for future improvements including the physical infrastructure, staff retention, training, quality improvement and quality assurance.

The senior leadership team assessed that the current physical infrastructure requires an upgrade, since little work has occurred since being built 40 years ago.

Concerns were noted from staff about staff attrition and that nursing recruitment was very challenging. At the time of the inspection, there were eight registered nurses employed with seven vacant posts being provided through 'Dedicare' agency, which increases cost. Vacancies spanned across general nursing, midwifery and community care. It was noted, however, that in the winter the hospital is quieter, which makes it easier to cope with fewer staff. It was felt that recently, hospital-based nursing was put under pressure due to prioritisation of the new community care facility under development at Tussac House.

In terms of training, staff highlighted an opportunity for continued professional development to bring all staff to the same level of competency, and potential to utilise link nurse educators to firstly train and then become trainers within KEMH. The Chief Nursing Officer checked all the PINS for registered nurses and checked their revalidation status monthly. We feel, however, that ordinarily it would be expected that the Chief Nurse would also undertake re-evaluation of permanent staff in-house. Time was allocated for mandatory training but there was some initial uncertainty around the level of engagement, though a graph was produced later during the inspection showing uptake. Appraisal rates for the employed nurses and healthcare assistants was not known.

Working practices appeared safe and effective, but there were sometimes procedural differences among staff due to the diversity of previous work experience, protocols and guidelines that they were familiar with. Staff feedback suggested that standardised, evidence-based procedures and protocols would be useful to support new staff and integration within teams. Staff identified general nursing and nursing care of paediatrics, in particular, as areas that may benefit from this.

The apparent lack of confidence in - or engagement with - reporting safety concerns or actual or potential safety incidences using 'Q-Pulse' is discussed in more detail in section 5.5. above, since it pertains to the whole hospital rather than specifically a ward-based issue.

There were regular checks of equipment and drugs, but there was no documented programme of audit; simple cycle of ward-based clinical audits would give assurance in this respect.

8. Theatre

8.1. Description of the service

The hospital houses a well-equipped operating theatre suite with 24-hour capability for patients requiring surgery, staffed by a rotational consultant general surgeon, an anaesthetist, four nurses or operating department practitioners (ODPs) who also assist the anaesthetist during management of ventilated patients, a decontamination supervisor and visiting specialists. The surgeon and anaesthetist posts were managed through an outsourced service contract.

On average, over 500 surgical procedures and interventions take place each year, excluding procedures carried out by visiting specialists. The anaesthetist cares for both adults and children and manages patients who require intensive care in conjunction with the on-call doctor.

8.2. The safety of the service

The theatre was well equipped and appropriate measures were in place to ensure cleanliness, infection control and hygiene. All surgeons working at the hospital must have basic orthopaedic competencies and be able to undertake caesarean sections.

In emergencies, a best effort was made for a range of trauma and medical situations if it was deemed to be in the patient's best interests. However, if the patient could be stabilised and transferred overseas for specialist treatment, this was usually the preference.

An anaesthetics advisor and a separate surgical advisor visited annually to undertake an assessment and provide recommendations.

8.3. The effectiveness of the service

The surgeon performed both elective and emergency procedures, with some elective procedures being undertaken by a comprehensive programme of visiting specialists.

The central sterile supply department undertook decontamination, sterilisation and endoscope processing. This was felt to be well-managed, although the facilities were not to contemporary UK standards, including, for example, a doorway that requires replacement with a different format to align to best-practice.

8.4. How caring the service is

The team felt that they work autonomously, which is a strength when managing emergencies and major incidents. The theatre and ward maintain close contact with ward nursing and auxiliary staff assisting with theatre workload and facilitating patient flow, supported by a circulating assistant. This is particularly important to ensure that on-call services are managed well, though the approach was felt by staff to be challenging in terms of the required time commitments. While opinions may vary, a

recent concern of a staff member, however, related to recovery facilities after anaesthetic in the absence of a theatre recovery area with some dedicated expertise.

Feedback from the public mentioned a kind and straightforward process and that they were impressed with the treatment they received.

8.5. The responsiveness of the service

In addition to emergencies and elective interventions, the department assist during medical evacuations to Mount Pleasant Complex and South America. A comprehensive programme of visiting specialists throughout the year ensures that a wide range of elective surgeries can take place, reducing the need for medical transfer overseas of patients.

The department had fluctuations in activity, aligned to seasonal variation due to tourism and the fishing industry (which has a high-level of workforce accidents, often involving significant trauma), and the visiting specialist programme. A key challenge for the service, however, was having only one substantive anaesthetist in post. This presented an issue of resilience, particularly in terms of managing high caseloads due to seasonal fluctuations and major incidents. It also prevented the anaesthetist leaving their location in the case of a time critical aeromedical transfer, for example. There was a small group of anaesthetists who came regularly to the Falkland Islands, however, and provided continuity of care. They spoke to each other regularly and undertook Morbidity and Mortality (M&M) meetings over Teams. The meeting that we witnessed had good attendance and good multi-professional engagement. The meeting covered a range of patients and presenting conditions. In keeping with the breadth of the workforce, there was a holistic and multi-professional approach to the cases.

In the case of major incidents, some of the theatre staff were deployed to casualty to assist with triaging and those requiring surgery are brought forward, while other team members set up the theatre and undertook mandatory checks. There was a modest time of approximately 1.5hrs between surgeries.

8.6. How well led the service is

There was a strong sense of a collegial culture among the theatre team and a desire to continually reflect on – and improve – service provision. They independently identified the need for – and developed – a plastering facility and relevant competencies, though staff had concerns that the size of the room is impractical for some types of plastering. Upgrading of the current theatre facilities was an aspiration of the KEMH, specifically in respect of creating a dedicated space for minor operations.

Staff that we spoke to were highly motivated to capitalise on the opportunity to broaden their skill mix by learning from visiting specialists and gave specific examples of techniques they would like to develop in this regard. The drawback of dependence on locums, however, is the potential for interruptions to continuity of care, though with good communication processes, this should be possible to mitigate.

The team regularly undertook general CPD and had an annual budget of £15,000 to support further CPD, for which needs were identified and prioritised by individuals and line managers, often aligned the requirements of the Health and Care Professions Council, UK.

Policies and procedures were maintained and updated by the substantive anaesthetist.

Within the hospital, the theatre department previously ran mock fire scenarios to inform their local plans in respect of a major incident of this nature.

9. Medical Treatment Overseas

9.1. Description of the service

In view of limitations to the range and quality of certain services that can be feasibly offered in the Falkland Islands, Medical Treatment Overseas (MTO) is key to the KEMH operational model and is underpinned by a MTO policy. Emergency medevacs are sent to South America, and the KEMH had agreements with the British Hospital in Montevideo (Uruguay) and Clinica Allemana in Santiago (Chile).

The most time critical medevacs are generally sent to Montevideo because it is the shortest flight time. The MoU with the MoD governs the circumstances in which the A400/ Voyager airframe stationed at Mount Pleasant may be utilised by the KEMH for aeromedical evacuation. If this option is selected then the KEMH provide the medical team to transfer the patient, though this decision is balanced against the risk of a depleted medical team remaining on the Falkland Islands. Most medevac transfers to South America are, however, by private air ambulance.

Most elective referrals are sent to the UK via the reciprocal healthcare agreement with the NHS. There are approximately 250 transfers per year, with 85% being planned and 15% as emergencies.

For routine MTOs, most patients go to Southampton, where there are long-standing relationships. The team can arrange for patients to become temporary residents with particular GP practices in the city. Patients also go to Charing Cross for ENT, Salisbury for rheumatology and Oxford. For routine MRI scans and nerve conduction studies, the preferred place of referral is Chile. Since mid-2023, elective arthroplasty has been via a private contract with Spire Healthcare. There were typically between 20 and 30 patients in the UK at any given time. At the time of the inspection, there were more than usual because of a special contract with Spire Healthcare for hip and knee surgery.

9.2. The safety of the service

In some circumstances, outside the control of KEMH, emergency medical evacuation did not always occur as swiftly as would be optimal owing to logistical issues such as the airport being closed when rotor winds are forecast. Overall, however, we were satisfied that there was no evidence of significant safety concerns with the service.

9.3. The effectiveness of the service

Emergency evacuations/transfers were administratively labour intensive, but the team operated a one-in-four rota to cover the work. A medical team from KEHM accompanied emergency (A400 / Voyager) evacuations, ensuring patients received care enroute, though the consequence of this was a reduced staff base at KEHM and therefore reduced resilience.

Sometimes blood test results were lost in the NHS system and did not find their way to the specialist in the UK or KEMH. The extent of the risk in this, however, was unclear, nor if any incidents had been recorded.

9.4. How caring the service is

There appeared to be an excellent support service for patients receiving care out of country. Having a nurse at the core of this function with good administrative support in the MTO office is certainly an area of excellent practice. Patients were also helped to find accommodation for which KEMH used several regular providers.

There was a particularly good and long-standing relationship with Southampton in the UK for MTO. The specialist liaison nurse could register patients with a GP surgery there, so that they have an NHS number and a temporary resident status.

The specialist liaison nurse liaised with - and signposted patients - to the Steven Jeffrey Fund and the Cancer Support Awareness Fund to help find additional support for patients who travelled overseas. The Steven Jaffray Fund is in honour of a 21-year-old man who died on a medical transfer in 1992 in South America. His then partner is the main trustee, and they raise money to support people with the costs of flights and care overseas which includes, for example, subsistence money over and above that given by FIG and support for relatives. Their annual budget was in the order of £65k per year and they did not means test any requests. They aimed to support whoever approaches them, though they were unsure if their existence is known by all potential recipients. The Cancer Support Awareness Charity provides support for patients who have cancer and need to travel overseas for treatment. They also offer support when the patients are back on the Islands. They appeared to be well connected and able to garner community support where needed.

As there is, by necessity, information that flows between the health service and the charitable sector, there are possibilities for breaches of confidentiality, and it wasn't clear how experienced the charities are in managing the information governance risks. In the light of general concerns about confidentiality expressed during the inspections, we suggest that care is taken to ensure the charitable sector generally is aware of its responsibilities and obligations in this regard.

9.5. The responsiveness of the service

The hospital employed a specialist liaison nurse nurse in mid-2023 who reports clinically to the Chief Nurse. The scope of the role was to provide care and support to patients referred for MTO as well as managing a caseload of patients on the islands with complex long-term conditions. The specialist liaison nurse also administers chemotherapy to some patients as part of their role, in addition to administering infusions of monoclonal antibody medication to an increasing number of patients. The specialist liaison nurse illustrated the ethos of the registered nurses generally in that they seemed comfortable working across areas of the nursing team workload as needed. They described, for

example, operating as a palliative care nurse / district nurse when the clinical case necessitated it. Two administrative staff support the MTO process, and a member of the administration team is on-call 24/7 to provide support for an emergency medevac should one occur outside of normal office hours.

All MTO patients have the specialist liaison nurse's email address and phone number and were able to make contact before and during their MTO. Overall, the results of the MTO patient satisfaction survey from 2023 were largely positive, with 90% of respondents being extremely satisfied or very satisfied with the process, 8% being satisfied and one non-responder. Of the 38 respondents, 93% reported that their GP had explained the reason for the referral, 100% felt that the MTO coordinator had clearly explained the process, and at least 90% felt that adequate information was provided about transport, appointments, accommodation and allowance / reimbursement, that opportunities were made to discuss concerns, and that the MTO coordinator was helpful. On return, 5% of respondents felt that their GP didn't provide adequate information and 63% were either unsure or did not answer the question. Free text comments were largely extremely complimentary about the service and the treatment received. Written public feedback that we received about the MTO service included an example of someone who reported they felt well supported but that travel arrangements was last minute and stressful. Other written public feedback mentioned a perceived lack of guidance being provided prior to MTO, though it is unclear if the examples predate the appointment of the specialist liaison nurse. Staff noted that arrangements for MTO are sometimes made with short notice, though it was unclear whether this was within the control of KEMH. To further support patients prior to – and while undergoing MTO – it could be useful for KEMH to develop a toolkit of practical advice including, for example, how to book taxis, how to purchase and use mobile phone sim cards, and to manage expectations in terms of the type or different types of care they should expect to receive.

One clinical area of note we discussed is the diagnosis of possible retinal detachment; this was a challenge on the Falkland Islands in the absence of optometrists and ophthalmic surgeons and accounted for a number of transfers to the UK annually. It may be possible to increase diagnostic accuracy using a computerised retinal tomogram using, for example, a system called "Optos". The inspection team will gladly support with exploring this if required.

9.6. How well led the service is

We found evidence of a well led service, and one in which there is effective collaborative working with the MoD and overseas treatment centres. We did identify a need, however, for closer liaison with MoD around joint transfers on the MoD A400 / Voyager to clarify and agree arrangements and to manage expectations, particularly in view of any forthcoming changes in respect of resource availability.

The MTO budget was allocated separately to the overall health and social services budget, so that financial constraints in one budget did not impact the other. The FIG recognised MTO as a demand-led service, and it was possible for KEMH to exceed the allocated budget without needing to ration or delay referrals. MTOs are increasing in number, and this is a clear cost pressure for the FIG.

There were agreed allowances for patients travelling overseas for treatment. There had been appeals for funding for a companion to accompany the patient which were dealt with on a case-by-case basis. In addition, however, (as described above) two charities offer additional support to patients: The Stephen Jaffray Memorial Fund offers financial support, and the Cancer Support Charity offers financial and pastoral support to patients who are referred for cancer investigation/treatment.

We were pleased to note that there was a weekly MTO MDT meeting, chaired by one of the MTO administrators, which the relevant doctors (specialists and GPs) and nurses attended. The meeting had contemporaneous notes taken that acted as an audit trail which are kept in books in the MTO office.

Many of the patients returning to the islands needed follow up, including, for example, monitoring blood tests. The MTO nurse operated a call-recall system in an Excel Spreadsheet that was housed on the 'Y' Drive and puts alerts on EMIS. While the latter is felt by the specialist liaison nurse to be somewhat ad hoc, there are 'Preferred Place of Care' and DNACPR alerts on the system. It seems that the governance challenge, therefore, is around the reliability of the call-recall systems and incident reporting if things don't go to plan.

A future potential risk to the service that was highlighted by the MoD is the possibility of losing access to the A400 Voyager. We would therefore encourage KEHM to consider contingency plans should this become a reality.

10. Pharmacy

10.1. Description of the service

The KEMH pharmacy is the only one in the Islands and is staffed by a full-time pharmacist, two pharmacy technicians and a pharmacy assistant. The pharmacy is on the ground floor next to the clinic rooms. It is small and space for storage and preparation of prescriptions is limited. It sells a limited range of over-the-counter medicines, but most items are issued via prescription. All prescriptions come to the pharmacy and are printed out. The pharmacy is open from Monday to Friday, between 9:30am and 12:30pm, and between 1:30pm and 4:30pm.

10.2. The safety of the service

The pharmacist, who is on a four-year contract, spent a great deal of time procuring medicines for the pharmacy and trying to optimise cost, and felt that stock control and restocking on the ward was reliable and controlled drug management was robust. Pharmacy supplies were sourced from a variety of wholesalers, including contacts in Turkey. There was a basic antibiotic formulary on site, and where there are concerns about infectious diseases and antimicrobial stewardship, the pharmacist could contact Porton Down in the UK for advice.

10.3. The effectiveness of the service

We found evidence of patient-centred care, team-based care in partnership with physicians and a high level of professionalism. In view of new doctors arriving regularly, the pharmacist undertook an induction with them, during which they explain how the medicines module of EMIS works and its limitations. The prescribing formulary was based on the British National Formulary and sats within

EMIS. Unfortunately, because the version of EMIS is server-based, the formulary was not updated, and this required work arounds to be able to prescribe newly introduced drugs.

10.4. How caring the service is

In addition to providing person-centred care, the pharmacy worked with patients and the public to improve health and medicine understanding. An example of this is that the pharmacy also managed the smoking cessation clinic, which provided free nicotine replacement or prescription items, along with support and advice. We understood that this was due to stop, however, and a new service would be starting imminently.

10.5. The responsiveness of the service

Prescriptions are free to all eligible Falkland Islands and UK residents. Patients in remote rural locations receive their medication through the post, including the replenishment of items kept in medicine chests. However, the pharmacist feels that "home remedies" such as paracetamol and ibuprofen are too often prescribed and dispensed from the pharmacy when they could be bought at the supermarket.

10.6. How well led the service is

The pharmacy team had the necessary experience and integrity to deliver the service and promoted a positive culture and collaborative culture among staff. While we saw evidence of safe practice, the pharmacist acknowledges that there is little incident reporting around medicines and felt that they do not have capacity to do this or to follow up on incidents. Similarly, there was no reporting into prescription trends over time. It was felt that polypharmacy is an issue on the Falkland Islands and a strong case was made for investment in a pharmacy technician to support with procurement and release the Pharmacist to undertake more medication reviews.

Out of the c. £19 million annual Health and Social Services operational budget, the drug spend was approximately £1 million. While this seems low in comparison to other healthcare systems which typically spend around 10% of their budget on medication, the budget covered Health, Social Care and Social Services (including income support). Once Social Care and Social Services costs were removed, the health operational budget was approximately £13.5m.

11. Laboratory

11.1. Description of the service

The laboratory is a multi-disciplinary department that runs two distinct service provisions: clinical pathology testing, and food, water and environmental testing.

The department employs five scientist level staff, who all have specialist skills and knowledge areas across haematology, microbiology, and food and water, providing the department with a robust ability to take on a range of testing services. The department is further staffed with two support staff who have worked in this generalist environment, and therefore have a broad range of skills.

The pathology service is quite comprehensive, given the context, and offers a wide range of tests including point of care testing, microbiology testing of a range of pathogens, haematology testing, biochemistry testing, urine chemistry testing, and coagulation testing. Cytology and histology services, as well as some biochemistry, immunology, haematology and coagulation, and microbiology tests are outsourced to QAH Portsmouth, which is an accredited laboratory in the UK, with support from MoD transport routes.

11.2. The safety of the service

The department were well positioned to undertake urgent tests to ensure patient safety, and while reliance on outsourcing of some testing to the UK resulted in protracted turn-around times for results, we were satisfied, based on the type of tests, that this did not present a significant safety concern that would impact on patient care.

All staff were appropriately trained, according to UK standards, and the service itself operated to UK standards. The department were highly committed to, and had built, a quality management system which governed all activities undertaken. In addition, the department had applied for UKAS accreditation of their food and water testing service which we believe was due to be awarded imminently and had ambitions to apply for accreditation of the pathology service in future.

The International Health Regulations (IHR) 2005 are a legally binding agreement of 196 countries, which include the Falkland Islands as a UK Overseas Territory, to build the capability to detect and report potential public health emergencies worldwide. The World Health Assembly first adopted IHR in 1969 to cover six diseases, which has since been revised multiple times. Countries reference IHR (2005) to determine how to prevent and control global health threats while keeping international travel and trade as open as possible. The IHR (2005) is legally binding; all WHO member states must report events of international public health importance. More specifically, the IHR (2005) requires that all countries can:

- Detect: Make sure surveillance systems and laboratories can detect potential threats.
- Assess: Work together with other countries to make decisions in public health emergencies.
- Report: Report specific diseases, plus any potential international public health emergencies, through participation in a network of National Focal Points.
- Respond: Respond to public health events.
- Of relevance to the Falkland Islands is that the IHR (2005) also includes specific measures countries can take at ports, airports and ground crossings to limit the spread of health risks to neighbouring countries, and to prevent unwarranted travel and trade restrictions.

Since the UK Overseas Territories returns fall under the umbrella of the IHR (2005) annual self-assessment annual reporting return, it is important that all in-scope countries strive to uphold and improve compliance. Based on the evidence we observed, we were satisfied that the service offered at KEMH is well positioned to meet these regulatory requirements. We would, however, encourage the service to consider – perhaps in liaison with UKHSA - how they would manage new and emerging threats, such as, for example, Monkey Pox, where capacity for testing is not yet established.

11.3. The effectiveness of the service

An algorithm was used to determine whether to outsource analysis to the UK or whether to undertake in-house, and an impressively comprehensive laboratory manual was available for use across KEMH which outlined the full range of services offered, how to access them, how to prepare samples, turnaround times, and what to expect from the laboratory reports. Where such a manual is not already available within other UK overseas territories, we would encourage KEMH to share this as a useful resource.

Molecular diagnostic capabilities within the laboratory had expanded since COVID and include rapid PCR screening (e.g., for respiratory viruses) using a Gene Expert platform and open-source facilities. A BIOFIRE platform was also available for use but in view of the high costs associated, clear criteria had been devised to assist with its rational use. If reagents were approaching expiry, the platform would, however, be used to limit wastage. Since other UK Overseas Territories also have BIOFIRE platforms, we would encourage KEMH to share, where appropriate, the criteria they have in place to support rationale and efficient use of the platform.

The department undertook avian flu testing, which is important economically (for tourism), as well as from an ethical and responsibility perspective. The department also provide a blood bank that routinely manages blood component stocks of red cell concentrate and fresh frozen plasma supplied by the Centre of Defence Pathology (CD Path). If required clinically or in the event of an emergency this stock may be supplemented by activating an emergency donor panel (EDP) which is managed by KEMH personnel and provides access to fresh whole blood from a panel of approximately 200 pre-screened donors on the Falkland Islands. An assurance visit was undertaken by SO2 Responsible Person (Blood) and Quality Lead from the MoD in April 2024 to ensure appropriate management of blood and the emergency donor panel. The assessment was based on UK regulations, Good Practice Guidelines and the use of CD Path standard operating procedures for EDP. Of note is that no critical or major non-conformities were identified.

11.4. How caring the service is

The staff member that we spoke to was highly professional, well aware of their responsibilities and extremely committed to upholding the very highest standards around quality, as well as being mindful of the sustainability of the service in terms of physical resource requirements, financial responsibilities and staffing needs.

11.5. The responsiveness of the service

Results for tests undertaken at KEMH were typically made available in the same day, with urgent results being available within 1 hour. As described above, where capabilities were not available at KEMH, referrals were made for diagnostic testing to a hospital in Portsmouth, UK. Harmony testing for pregnancy was sent to HALO Precision Diagnostics, but via the Portsmouth hospital, to ensure that the logistics and oversight arrangements followed a consistent process. The turnaround time for referred samples was typically 2-4 weeks but sometimes results would be returned within one week.

Cross-training of biomedical scientists to broaden skills mix was actively encouraged – and we were very impressed with the depth of knowledge and skills of the team. For example, in the event of equipment failure, the staff had been able to undertake tests manually at the bench using traditional

methods. This is impressive and not necessarily a skillset that is common among biomedical scientists.

All equipment was available in duplicate to ensure service continuity. In addition, the laboratory manager had an excellent understanding of the equipment, kept a stock of spare parts, and was able to undertake some repairs to save the time and cost of recruiting external engineers.

A major incident plan was in place and the laboratory undertook mock incidents every 2-3 years. In the event of a major incident, the veterinary service would be available to support with taking blood donations if required.

In view of there not being clinical consultants employed at KEMH who would ordinarily interpret results, the laboratory liaised with consultants in Portsmouth, where required. Due to the broad and detailed skills mix of the laboratory team, however, they were well placed to assist with analysis of most routine diagnostic test results, with only some microbiology results typically requiring a higher level of interpretation and clinical support.

11.6. How well led the service is

The laboratory lead had the experience, capacity, and capability to ensure delivery of a high-quality service and risks to quality were actively monitored. The department were knowledgeable about issues and priorities for the quality and sustainability of services, understood what challenges exist and acted to address them. The team felt that they worked autonomously and felt well supported by KEMH.

There was a high dependency on locum staff, with three of five scientists being locum (the two lab technicians were local). The laboratory manager felt that this was inefficient and costed in excess of the cost of employing three permanent staff. We understood that staff were not paid competitively which presented a recruitment and retention challenge, especially since they arguably worked to a level beyond what would be typically expected. As a solution to this, the department sought to encourage Biomedical Science as a career opportunity for permanent Falkland Islands residents and undertook outreach activities with Falklands College to support their provision of bespoke career apprenticeships. In addition, they were committed to accepting students studying in relevant science disciplines to undertake work placements with them during their term holidays.

The department utilised the ‘Q-Pulse’ system for all quality management aspects, including storage of policies and protocols and quality assurance data, and it was felt that the system was used to a fuller potential compared with the rest of the hospital. Their system was separate from the main one in use at KEMH since they had pioneered its use prior to the rest of the hospital. Much of what is contained within it would not be applicable broadly to the hospital and it was therefore deemed unsuitable to fully merge and integrate with the main hospital ‘Q-Pulse’ system, though key necessary information was duplicated into the hospital system, where appropriate and relevant.

Monthly quality meetings took place, in addition to customer meetings and satisfaction surveys for public health and clinical pathology services. Feedback was presented to the CMO and director of health and social services including on the number of samples processed, expenditure, call out events, and plans for future developments and staff requirements. In addition, there was a regular, planned cycle of audits in place, based on three per month over a two-year schedule.

The laboratory department recognised the importance of investing in staff and providing opportunities for career progression. The KEMH laboratory is an Institute of Biomedical Science (IBMS) approved training laboratory to support staff (Certificate of Achievement Levels I and II) and pre-registration (Certificate of Competence) level. The department held a list of mandatory training requirements on 'Q-Pulse' which staff were expected to undertake every 2 years. Some elements are flagged on the system to alert about renewal dates. The laboratory manager was actively working hard to ensure compliance with mandatory training and aimed to undertake an audit in Jan 25 to check on progress.

12. Electro-Biomedical Engineering

12.1. Description of the service

KEMH houses an Estates and Engineering Department which employs electro-biomedical engineers that manages the maintenance of the hospital's medical equipment (~700 items) including critical medical life support equipment, radiology, laboratory and dental equipment. Maintenance, acceptance, test, repair and calibration services are provided for a range of high risk and technically complex equipment in the hospital and associated clinical areas, including specialist infusion pumps, syringe drivers, defibrillators. The department also provide technical advice and support across a wide range of equipment related matters which include supporting staff requests.

12.2. The safety of the service

Using a maintenance management system, the department ensured that all equipment was maintained to manufacturer's recommendations and that all work was recorded and documented accurately. Maintenance covered a broad spectrum of disciplines for which the engineers ensured adherence to manufacturer's service requirements and relevant policy, legislation and guidance.

12.3. The effectiveness of the service

The department assisted in the management, administration and support of maintenance contracts held with external contractors and were responsible for producing accurate and direct records for technical servicing on equipment.

Accessories and spares were ordered as necessary, and stock control was managed for a defined group of equipment spares as required including, for example, a dental chair and anaesthetic equipment.

The maintenance management system was used for tracking maintenance timelines according to manufacturer guidelines, and an asset log was used to track equipment life cycles. At the end of its lifecycle, major equipment was no longer used, and plans were made proactively for renewal, where relevant.

12.4. How caring the service is

The staff we spoke to were highly professional, well aware of their responsibilities and very collegiate.

12.5. The responsiveness of the service

The department had a robust system for prioritising work, and dealt with emergencies that arose with equipment, including providing an emergency out of hours service where required to resolve technical problems.

12.6. How well led the service is

Staff were trained to HNC/D/Degree level in electrical / electronic engineering or medical physics and had undertaken formal EBME training on critical and lifesaving equipment. Personal development plans were used for continuous training as required.

The service assisted the hospital' s head of estates and engineering with the continued development of the hospital
capital program and liaised with overseas manufacturers and service providers to gain best value for money and technical support.

13. Public health service

13.1. Public health service

While out of scope of the inspection, we took the opportunity to meet with the public health practitioner at KEMH to learn about the service offered. We understood that the role had transitioned from being policy focused to one with more of a health focus, though the remit of the service was not aligned to what would be typically expected within public health. More specifically, there was little focus from the FIG on health and care preventative strategies. There was, however, an aspect of the public health role that linked to child health and health promotion in the schools, and the practitioner undertook 1:1 lifestyle support sessions that incorporated diet and exercise.

The public health practitioner wrote a public health strategy in 2018-19 at the FIG's request, but it did not appear to have been actioned. There was also recently a proposed tobacco strategy, including smoking cessation support and ways to reduce vaping; this, along with the full range of measures proposed as a part of a comprehensive strategy, was not supported by the FIG. ExCo instead asked officers to return with a plan of more easily achievable measures, the effectiveness of which would likely to be rather more limited.

Immunisation rates were unknown by the public health service, though the 0-19 service knew the immunisation rates of children.

Every citizen in the Falkland Islands is registered in the same system which connects between general practice and the hospital system. This presents an excellent opportunity for the public health service to consider the longitudinal care of the population in terms of secondary prevention of long-term conditions such as hypertension, diabetes, chronic lung disease, heart disease, liver disease. We encourage KEMH to consider how the role of the public health department could be evolved to make best use of this data to support a healthcare prevention programme, particularly focused on chronic disease management.

14. Other observations about services not in-scope of the inspection

14.1. General practice service

During the inspection, we met a GP who had worked at KEMH several times over recent years but was planning to move imminently to another overseas role. The GP described enjoying the work and felt that there are plenty of appointments available for patients. The GP noted that there are more GP-type appointments available per capita than is the norm in the United Kingdom.

The GP worked in the emergency department which was used by some as a drop-in service. During out of hours, if on-call, KEMH expects patients to ring before they present to the department, though they often would just arrive without notice. The preference of the GP would be to offer a morning clinic, organised into appointment slots, but this would require additional staffing, which was felt would be unavailable.

Doctors can access the pharmacy out of hours if they need to, but it is felt that the drug formulary is sub-optimal as it cannot easily be updated in the version of EMIS PCS. In addition, the prescribing module is deemed to be poor, and laboratory results are not in EMIS, but on another system called 'Labvantage', while X-rays are in another system. Polypharmacy – i.e., the practice of taking or being prescribed too many medicines – was felt to be problem and it was felt that capacity this could be more effectively addressed with medication reviews by pharmacists.

Additional future development opportunities that were highlighted included improvements to the call/recall systems, and as described in section 13.1., better lifestyle advice including, for example, for obesity management and smoking cessation. With a better IT infrastructure, there would also be the possibility of encouraging more remote consultations and facilitation of remote specialist consultations where, perhaps, the patients and GP could be in the clinic in KEMH and the specialist in a separate country.

14.2. Maternity service

In determining the remit for the inspection, it was agreed to exclude maternity services, noting that an external review had been undertaken in March 2024, aligned to an ongoing inquest into a death of an infant. An action plan has been agreed for the maternity service reflecting the recommendations of the review and maternity service staff were implementing the actions. In addition, an externally commissioned independent review was also completed. Since maternity services were out of scope of the inspection, we recommend that KEMH conduct a follow-up service evaluation into these services before the end of 2025 to review progress against any association actions.

Although the service was out of scope, we have chosen to provide some comment on the area, in view of feedback received from the public highlighting disappointment that they had been unaware of the review – and that they would have expected that as part of the review, the views of service users would be sought, and the terms of reference for the review to be made public. Feedback also referred to perceived excessive working hours of staff working in maternity services that gave cause for safety concerns and asked whether there was evidence of recording and learning from near misses, and whether audits are undertaken to ensure that measures were effective. While we are mindful of the ongoing inquest and potential for this to be undermined by public disclosure of information, we encourage KEMH when appropriate, to produce a public communication about lessons learned and resulting actions that have been taken. More broadly, in future, we encourage KEMH to consider their approach to public engagement to build trust and provide reassurance, where appropriate, that appropriate measures are being taken to address concerns and issues that arise.

15. Appendices

Appendix 1. Record of meetings attended

Abbreviations:

IC - Ian Cumming
JG - Jim Gardner
HF - Heidi Fuller
PM - Pete Murphy
JW – John Woollacott
RE – Rebecca Edwards
MH – Mandy Heathman
JV – Janette Vincent

Tuesday 12 November 2024

- Emergency department and ward (JG & PM)
- Kick-off presentation with senior management team (IC, JG, HF, JW, RE, MH & JV)
- Chief medical officer focus (IC, HF & RE)
- MTO co-ordinators (Nyree Heathman, Racquel Francis & JG)
- Pre-hospital care / ambulance (Alexis Zamora, IC & HF)

Wednesday 13 November 2024

- Healthcare governance manager (JV & JG)
- Chief Medical Officer Acting Chief Medical Officer (Rhys Cottle, RE & JG)
- Chief Nursing Officer (MH & JG)
- Emergency care (IC, HF, MH & RE)
- Ward / casualty (Louise Dempster, IC & HF)
- General medical care (Matthew Weinig & JG)
- Public meeting (public x 4, HF, IC & JG)

Thursday 14 November 2024

- Ward – from 07:30 handover (JG, MH & Janice Dent)
- Emergency planning (IC, HF, JW, RE, JV & MH)
- MoD Mount Pleasant Medical Centre (Simon Read and colleagues, HF, IC & JG)

Friday 15 November

- Specialist Liaison Nurse (Ellis Smith & JG)
- Stephen Jaffray Memorial Fund and Cancer Support Awareness Charity (JG, MH & Elllis Smith)
- Theatre (Eric Black, Jason Hegarty, Cath Livingstone, HF & IC)
- Anaesthetist (Cath Livingstone)
- MLA meeting (MLAs, JW, HF, IC & JG)
- Staff 1:1 meetings (x2) (HF)

Monday 18 November

- Laboratory (Chester Crowie & HF)
- Staff 1:1 meetings (x3) (HF)
- Further MTO meeting (Nyree Heathman & JG)
- Pharmacy (Matt Stratton & JG)
- Public health specialist (Carol Morrison & JG)
- Complaint handling (JW, JV & HF)
- Initial feedback to leaders (Andrew Potts, JW, RE, MH, JV, HF & JG)
- Media – Penguin Newspaper, radio, TV (JG & HF)

Appendix 2

Attendance at M+M Meeting on 28/11/24

Name	Role
Cath Livingstone (Chair)	Anaesthetist
Chester Crowie	Laboratory Manager
Janette Vincent	Healthcare Governance and Complaints Manager
Rebecca Edwards	Chief Medical Officer
Yvette Sherriff	Practice nurse
Mandy Heathman	Chief Nursing Officer
Ron van Doorn	Surgeon
Louisa Murray	GP
Toby Cockbill	GP
Shozab Ahmed	GP Trainee
Matt Weinig	GP
Rhys Cottle	GP/Acting Chief Medical Officer
Kelly Moffat	Physiotherapist
Natalie Muza	Therapy Assistant
Nina Aldridge-McLean	Senior Radiographer
Ellis Smith	Specialist Liaison Nurse
James Nash	Consultant Obstetrician and Gynaecologist
Peter Reemst	Surgeon
Sharn Browne	Medical Officer/GP
Claudia Tait	Midwife
Emma Browne	Medical Officer
Chris Richard (via Teams)	Anaesthetist
Jim Gardner	Assurance visit team

Apologies:

David Cowan Anaesthetist

Appendix 3: Documents reviewed

- Written feedback sent by email from KEHM service users and carers
- Letters of complaint submitted to KEHM forwarded by service users and carers
- KEMH code of confidentiality (issue date: July 2024)
- KEMH emergency call out procedure (issue date: August 2024)
- KEMH mandatory training policy (issue date: December 2023)
- MTO policy (issue date: V4.4. July 2024)
- KEMH complaints, compliments and comments policy (issue date: August 2024)
- KEMH complaints, compliments and comments departmental register template
- Memorandum of Understanding between the MoD and KEMH (issue date: November 2020)
- Secondary Healthcare Risk Review - British Forces South Atlantic Islands Sep 2023
- Blood assurance visit KEMH 25 April 2024
- KEMH Radiology DCA tiered hospital assessment 2024
- ITU admissions data (2019-2023)
- Deliveries data (2019-2023)
- Ward admissions data (2019-2023)
- Ambulance call-out data (2016-2024)
- Casualty attendance data (2023)
- List of visiting specialists to KEMH 2024-2025
- Data on visiting specialists to KEHM theatre per speciality (2015-2023)
- Theatre procedures data (2019-2023)
- Q-Pulse data on incidents, complaints and compliments (2023 & 2024)
- MTO patient satisfaction survey results (2023)
- FIG wide staff satisfaction survey results (2023)
- KEMH staff survey results (2023)
- KEMH live risk register
- Health and Medical Services Committee terms of reference ((20 of 1995) (6 of 2004))
- Health and Medical Services Committee agenda (24 July 2024)
- Director's report to HMSC (July 2024)
- KEMH business continuity plan (issue date: 14 August 2024)
- FIG health and social services major incident plan (issue date: July 2022)
- FIG major incident plan (issue date: 8 November 2023)
- Meals on Wheels public survey (11 November 2024)
- KEMH pathology handbook
- Health and Social Services Directorate Organisational Structure
- Attendance Management Policy (September 2019)
- Sickness Absence Procedure (revised February 2020)
- Conducting a 'Return to Work' meeting following a period of absence – a Manager's guide
- Draft Mental Capacity and Deprivation of Liberty Policy (2024)
- Draft MPower and FCTC Tobacco and Vaping Controls Framework Policy (2024)

Appendix 4: Electronic systems reviewed

- Q-Pulse (quality management software)